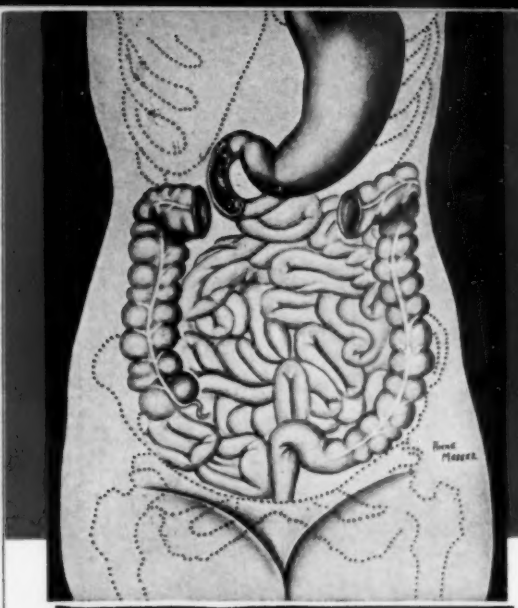
R.N.

A JOURNAL FOR NURSES

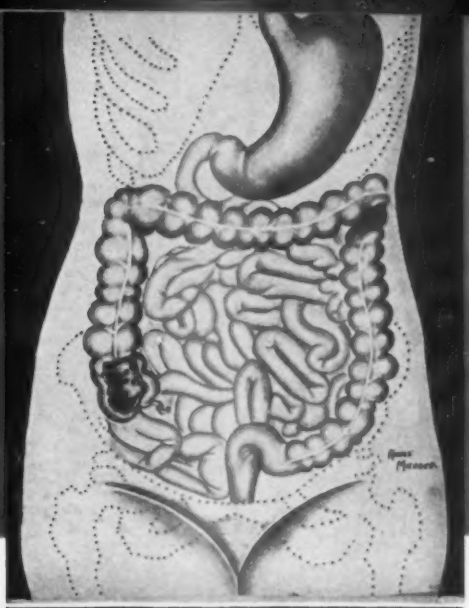
MARCH 1941



IN THE DUODENUM

Laxative action begins here

Because they are enteric coated, Taxol Tablets pass through the stomach whole. Thus gastric irritation is avoided, and potency of the ingredients is unimpaired by the gastric juice. The tablets are quickly dissolved beginning in the alkaline succus entericus of the duodenum. Laxative action therefore begins at the beginning of the intestinal tract.



IN THE COLON

Progressive action all the way

Solution of Taxol Tablets begun in the duodenum is continued throughout the jejunum and ileum, neglecting no part of the intestinal tract. The enteric coating now completely dissolved, the medication is delivered in the cecum, where it produces gentle stimulation of the entire colon. An anti-spasmodic ingredient prevents cramps or griping.

TAXOL TABLETS

THE PROFESSIONAL LAXATIVE

Taxol Tablets produce a comfortable movement in six to twelve hours, without cramps, griping or nausea. The advantages of Taxol Tablets, as explained above, form the basic reasons why this professionally advertised laxative is so widely prescribed by many physicians.

Samples of Taxol Tablets are available to registered nurses for their personal use, without charge.

• Mail the attached card today for your complimentary supply of Taxol Tablets

LOBICA, Inc., 1841 Broadway, New York, N. Y.

IN *This* ISSUE

March 1941 Vol. 4, No. 6

A JOURNAL RN FOR NURSES

Circulation over 100,000 registered nurses monthly. Editorial and business offices at Rutherford, N.J. DOROTHY SUTHERLAND, Managing Editor. MONA HULL, R.N., Editorial Associate. Advertising representatives: CYRUS COOPER, Eastern Manager, and GLADYS HUSS, Eastern Associate, Graybar Building, New York City; J. M. KEENE, Western Manager, 870 Peoples Gas Building, Chicago.

Debits AND CREDITS

QUANDARY

Dear Editor:

During the past year, I have done relief general duty in a rather small hospital, and during vacations, have also done supervision work there.

Recently, I discovered that some of the nurses who had been there for years were undergraduates, while others were graduates who had never received their R.N.'s.

On occasion, I have been called in on general duty, when one of these "nurses" was in charge. Since I am a New York State R.N., I feel that this practice is unfair.

I have flatly refused to come in any more until an R.N. is placed in charge when the supervisor is absent. Do you think I am right in this matter?

R.N., Mount Vernon, N.Y.

[*The personal opinion of* R.N.*'s staff is that this nurse is certainly right in her stand. What do other readers say?*—THE EDITORS]

COMPLAINT

Dear Editor:

Why must general-duty hours exceed forty a week? Why can't we have a day-and-a-half off each week? And why aren't our State and national organizations strong enough to govern such conditions for us?

General-duty nurses are also underpaid, and their living quarters in most institutions are pretty meagre. As things are now, R.N.'s have neither time nor opportunity for the recreation they need to keep well and happy.

I'd like to hear from other nurses. What can we do about this problem?

R.N., Hartford, Conn.

VOLUNTEER STORY

Dear Editor:

I'd like to relate the sad experiences of a nurse-friend of mine, Laura R. who, having specialized in surgery for years, thought she would volunteer to help make dressings with a local church group.

Laura, who could have folded all the gauze allotted to the whole group in less than two hours, was "supervised" by two society matrons. They hung over her with such bits of wisdom as "My deah! You musn't *crease* the gauze—just *pat* it," and "We find, Miss R., that your dressings measure 1/32 of an inch out of line."

Laura threatens to give up volunteer work altogether. Have other R.N.'s had such experiences?

R.N., Hobart, Ind.

[*Perhaps this* R.N. *could find more skilled volunteer work, such as Red Cross courses to teach, or local blood banks. How have others made out with volunteer work?*—THE EDITORS]

REMINDER

Dear Editor:

I'm just recovering from the "flu," and as I lie here in a hospital bed, I wonder why R.N.'s forget the fine points of nursing as soon as they graduate.

Why do we forget to make beds really *tight*, to keep pillow-case seams at the top of the bed, to give a thorough back-rub without slopping alcohol?

I hope I'll remember these all-important details when I get back on duty.

Dorothy A. Cowles, R.N.
Meriden, Conn.

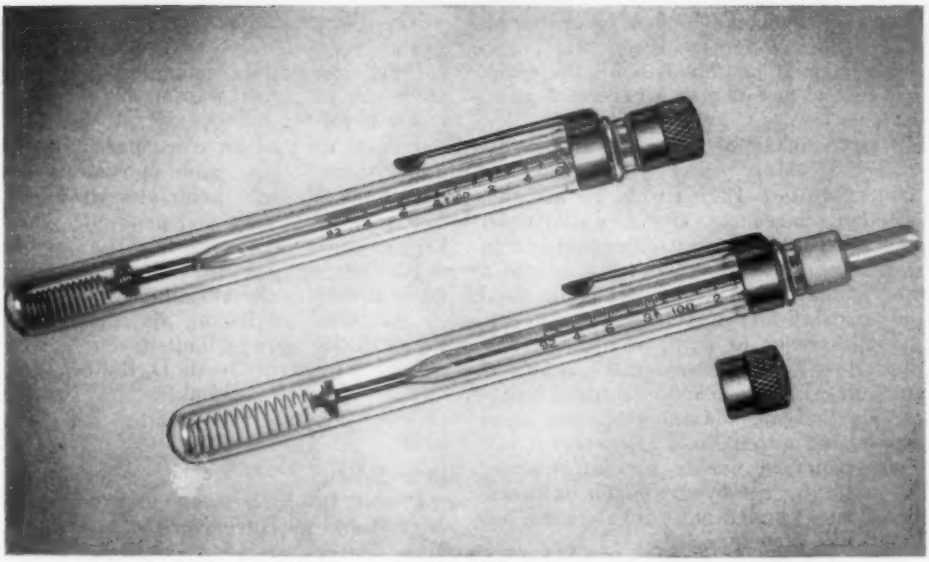
FIRST-AID KIT

Dear Editor:

One "thank-you" could never be enough for all the good things that come to me with each new issue of R.N. Perhaps if I say "thanks" each time I write, I may keep a credit balance.

I want to add my two-cent's worth to the letter from Miss Sele of California (D & C, September, 1940). If enough of us write in, describing our own first-aid kits, we will all gather new ideas. Here's how my kit is organized:

I bought a metal fishing-box in a local hardware store. It has the advantage of a tray, which lifts out of the top whenever



Isn't this the sterilizing case you have been looking for?

MOST nurses prefer to carry clean thermometers in sterilizing cases—but they don't want to pay too much for the privilege.

This new pocket thermometer steritube, of sturdy glass with stainless steel ejector spring, adds only 25c to the regular price of a B-D Thermometer.

Any sterilizing solution which does not affect stainless steel may be used. When the cap is removed, the ejector spring raises the thermometer so it may easily be lifted out—without spilling the fluid.

Steritube cases are available with B-D Medical Center Thermometers or the new easy-reading B-D Red Flash Thermometer in which the mercury column appears red.*

Your regular dealer carries B-D Thermometers in steritubes or can get one for you quickly.

**Your patients—especially those who have difficulty taking temperature readings—will be grateful if you recommend the B-D Red Flash to them.*

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON & CO.
RUTHERFORD, N. J.

the box is opened. The box measures fifteen inches long, by seven wide, and seven deep. It just about holds the entire pharmacy; and it goes wherever I go in my car.

I carry many of the same things described by Mary Anne Wood in her article (February 1941), with the addition of ether, paregoric, sterilized horsehair in a tube, and suture needles and gut in sterile tubes. The horsehair, made into a loop at the end of an applicator, is ideal for removing foreign bodies from the eye.

I'm in favor of going a little farther than Miss Wood advises, in the matter of ampoules. I always carry coramine, epinephrine, caffeine sodium benzoate, amyl nitrite, and adrenalin. I also carry a fine spinal-puncture needle for intra-cardial adrenalin, for use by any doctor on necessity. I once carried anti-snake venom, but found it a bit expensive.

I'd welcome suggestions from others on the contents of their kits.

R.N., New York, N.Y.

[*Other readers may disagree about the inclusion of ampoule medications in a nursing first-aid kit. Let's hear from more first-aid enthusiasts.*—THE EDITORS]

AGREES

Dear Editor:

I was in a doctor's office in a small town for nearly four years, and enjoyed that type of nursing far more than private and institutional work.

It's true, the salaries are not as high as they should be, and I used to "grumble" over the unending amount of work, but I wouldn't have given it up for any other nursing job.

The compensations were many: congenial acquaintance with patients, absorbing emergencies, community contacts, since my employer was on innumerable committees.

I do think that an office nurse should know some typing and shorthand, lab technique, and the principles of X-ray. She should also be a dependable bookkeeper and record writer.

It's my opinion that doctors realize more and more the advantages of an R.N. in the office, replacing the "assistant" whose duties were so limited.

Jessie D. Rafford, R.N.
Brooklyn, N.Y.

SLIP

Dear Editor:

Doctor Jacobson wants to express his interest and pleasure over the contents of Miss Street's article, "Relax," (R.N., November 1940).

However, he is completely mystified by the various references to him exclusively in the past tense. Particularly, the reference to "the late Dr. Jacobson" has occasioned considerable speculation as to whether he is still alive.

Dr. Jacobson himself has assured me that he is still very much alive and, as his secretary, I see no reason for doubting this. Accordingly, I assume that you will wish to make some sort of correction for your readers.

S. Metzger
Laboratory for Clinical Physiology
Chicago, Ill.

[*The editor's face is red! The author has her's buried in the sand. The only thing which spares the staff from com-*

Appetite Appealing

WHEN OTHER FOODS ARE REFUSED

During chronic illness, during the height of infectious fevers, and following surgery, the ingenuity is frequently taxed in providing nourishing foods that appeal to the lagging appetite and do not overtax the digestion.

New Improved Ovaltine, made with milk according to directions, is accepted by most patients with relish, though many other foods may be refused. Palatable and more easily digested than milk alone, it usually continues to appeal even to the most jaded appetite. The low curd tension of this pleasant food drink facilitates rapid gastric emptying, minimizing distention and epigastric discomfort.

The recommended three daily servings of New Improved Ovaltine, made according to directions, each with 8 oz. of milk*, provide in addition to proteins, fat, and carbohydrate, the following: vitamin A 2578 I.U., vitamin B_1 302 I. U., vitamin D 327 I. U., vitamin G 491 Sherman-Bourquin units, calcium 1.05 Gm., phosphorus 0.903 Gm., iron 8.9 mg. and copper 0.75 mg.

*Based on average reported values for milk

NEW IMPROVED *Ovaltine*

2 KINDS—PLAIN AND CHOCOLATE FLAVORED

Ovaltine now comes in 2 forms—plain, and sweet chocolate flavored. Serving for serving, they are virtually identical in nutritional value.

•

Registered nurses are invited to send for individual servings of New Improved Ovaltine. The Wander Company, 360 North Michigan Ave., Chicago, Ill.

plete misery is that Dr. Jacobson seems to be in excellent humor, as well as in excellent health!—THE EDITORS]

SUITED

Dear Editor:

I was interested in the letter from the Iowa office nurse (D & C, December 1940).

I have done office nursing for five years. Although the hours are extremely long and the salary small, I am very happy in this pleasant work.

I've nursed in institutions, done private duty, and public health work—but give me office nursing every time!

Effie S. Bowman, R.N.
Philadelphia, Pa.

CHEERS

Dear Editor:

Just another word of defense for Roxann! I'm sure that our friend from Brooklyn misunderstood her article. I always look forward with a great deal of pleasure to her human interest angle on nursing. We'd all grow old before our time if we surrounded ourselves with seriousness and gloom.

I'm not a "smoker," and yet I have had roommates who annoyed me as much as Roxann's. And I find nothing shocking in taking sun-baths in a bathing suit.

Let's not take the little pleasures out of life by eliminating "our Roxann."

R.N., Philadelphia, Pa.

[*Roxie thanks all her fans for their enthusiastic support. Sorry we haven't room to publish all the fan letters received. She will continue to let us in on her adventures.*—THE EDITORS]

OLD FASHIONED

Dear Editor:

I'm an old-timer. Am I right in saying the R.N. of today may be a wee bit to blame when it comes to the impression some people have of our profession?

Is it necessary, in order to relax, that the nurse must have her cigarette? What did we do to relax in the old days? Well. I confess tea had quite a place in our affections . . . But tea caused no lack of sureness nor was it an undignified habit.

In my training days, nursing was a pro-

ADVANCES IN CANNING TECHNOLOGY

III. Modern Heat Processes for Canned Foods

● "This new method of preserving . . . proceeds from the simple principle of applying heat . . . in a due degree to the several substances after having deprived them as much as possible of all contact with the external air."(1)

In this concise manner, Nicholas Appert, discoverer of canning, summed up the salient features of his procedure. Appert's method consisted of sealing prepared foods in wide mouth glass bottles with corks and processing the sealed bottles in a bath of boiling water. The first English edition of his book (1) describes Appert's procedures for some fifty products. While the times of his heat processes varied between products, the temperatures of the processes were uniformly that of boiling water.

After the spread of commercial canning to America, early canners soon found that spoilage frequently resulted when Appert's heat processes were employed. Increasing the time of process at 212°F. alleviated but did not entirely control this difficulty. As recently described (2a), attempts were next made to increase the temperature of process, either by the addition of soluble salts to raise the boiling point of water, or by the use of the autoclave which permitted processing under steam pressure at temperatures above 212°F. About 1874, an improved type of autoclave was invented in the United States and gradually came into general use for certain types of products. While this device reduced spoilage considerably, losses still occasionally resulted due to inadequate heat processing.

Between 1895 and 1900, the new-born science of bacteriology was first applied to the canning industry. These early discoveries are well described elsewhere (2, 3); important among the findings was the fact that for products most favorable for growth of spoilage organisms, there is a minimum time of process which must be applied at a given temperature for a given can size, if preservation of the food is to be assured. The need for standardization of heat processes was thus clearly indicated.

During the past twenty years, the heat processing of canned foods has truly been placed on a sound scientific basis (4, 2b). The natural acidity of the food now determines the process temperature to be used. Foods with pH values below 4.5 may be safely processed at 212°F. or below; the "non-acid" foods with pH values above 4.5 require elevated process temperatures, 240°F. being the temperature most widely employed.

Today, adequate heat processes for non-acid foods are mathematically calculated using data which take into consideration all factors influencing the sterilizing value of a process. Processes thus calculated are thoroughly tested before being incorporated into bulletins of recommended processes which modern canners follow (5).

This establishment of adequate heat processes—particularly for the non-acid foods—is one of the greatest advances in canning technology made in the history of the industry. Today, it is apparent that the success of many of Appert's heat processes was due to fortuitous circumstances. The modern consumer, however, has the assurance that commercially canned foods are among the most wholesome foods reaching his table.

AMERICAN CAN COMPANY, 230 Park Avenue, New York, N. Y.

REFERENCES

(1) 1811. Art of Preserving. N. Appert. Black, Parry and Kingsbury, London.

(2a) 1938. C. O. Ball. Food Research, *3*, 13.

(2b) 1923. C. O. Ball. National Research Council, Bulletin No. 37.
1928. C. O. Ball. Univ. of Calif. Publications in Public Health *1*, 15.

(3) 1937. Appertizing, A. W. Bitting. The Trade Pressroom, San Francisco.

(4) 1920. National Canners Assoc., Bulletin 16-L.

(5) 1939. National Canners Assoc., Bulletin 26-L, Fourth Edition.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-ninth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

fession—not a job. We were placed rather high among professions and that fact was always kept before us. Not to make us snobs, but to help us realize the great responsibilities and trusts placed in our hands. Maybe that is why some old-fashioned nurses feel sorry to see so many young nurses today marking time until their hours are over and stealing precious moments to smoke.

Today's makeup and nice hair-dos help very much and if not overdone certainly do not harm our profession. So you see I am not utterly hopeless . . .

Please let some of your readers express their ideas on this subject. I will enjoy being utterly routed!

R.N., Durango, Colo.

EMBLEM

Dear Editor:

One of my co-workers and I have been very much interested in letters regarding the cleanliness and comfort of short sleeves. Recently you published some comments on a chevron symbolizing professional nursing. We think the scheme is very good—particularly for short sleeves. It would be very attractive.

R.N., Washington, D.C.

LICENSE?

Dear Editor:

I am a married nurse, over forty who went back to general-duty nursing after fifteen years—and like it!

I do not believe practical nurses should be licensed. Licensing them is the same as giving them recognition. I think they have a place to fill in the health picture. But they are *not* professional nurses!

Also, there should be a distinction made between the R.N. and the graduate who is not currently registered . . .

R.N., Streator, Ill.

ROXIE'S CRITICS

Dear Editor:

Of course I enjoy Roxann! I think she hits the nail on the head almost every time. My criticism (which you published in November) was simply that she didn't enjoy hobbies. Remember, in one of her articles she wrote that she had tried them all and couldn't get a kick out of anything, not even the Red Cross.

Naturally, not all of us are built alike. For my part, I've got quite a lot of satisfaction out of Red Cross work . . .

Anna Berle, R.N.
Brooklyn, N.Y.

[*Miss Berle refers to Roxann's article on hobbies, "Maybe I'm Wrong—," which appeared in April 1939. Readers who remember this tale will recall that it contains no mention of the American Red Cross. Roxann, like thousands of others, also finds Red Cross work satisfying.*—THE EDITORS]

Dear Editor:

I have no objection to Roxann, but I think she could be a little steadier . . . I think she is somewhat on the jitterbug side, a bit negative in her impressions. I can imagine Jean's sigh of relief ["Live Alone? I Love it!" R.N., June 1940] when Roxie decided to live alone and like it. But still, I'll continue to read her stories. They are amusing . . .

Bessie Burt, R.N.
De Kalb, Ill.

Calling ALL NURSES

Is there someone in the profession you'd like to locate? You may insert here, without charge, a 75-word notice. Items will be published in the order received. Be sure to include your full name and address so that replies may reach you. Address the "Calling all nurses" editor.

MAY (or MARY) ROWSON: This nurse graduated, as I did, from the Brownlow Hill Hospital, Liverpool, England. Upon her arrival in this country (I think in 1921 or 1922), she became a New York State R.N. It is most urgent that I locate her. My training school, as well as its records, has been destroyed. Miss Rowson, who was Sister-in-Charge when I trained could give me the necessary data for my New York registration. Thanks to anyone who can help! Jane Hanley Bracken, 632 Sterling Place, Brooklyn, N.Y.

AUGUSTA M. STEIDLE. Cousins shouldn't lose track of one another as we have! Last time I heard from you, you were nursing in Chicago. I've tried through nurses' registries to locate you, without success. Won't you get in touch with me? Olivena Podvant, 803 W. 1st St., Coffeyville, Kans.

FLORIDA-BOUND R.N.'s: We'd appreciate it if nurses sending inquiries to this district would enclose return postage. Questions come so thick and fast that we cannot continue to carry the expense of sending replies. Thank you. Evaline Griffin, Secretary, Fifth District, Florida State Nurses Association, Miami, Fla.

ESTELLE GLASSMAN: Can anyone reading this notice tell me this nurse's address? She is a graduate of the Hartford Hospital (Conn.), and worked for some time at the Cedars of Lebanon Hospital in Los Angeles. Please send any informa-

tion to James P. Jones, Sylvester Apts., 2268 West 14th St., Los Angeles, Cal.

ST. JOSEPH'S HOSPITAL GRADUATES: (Tacoma, Wash.) Class of 1926. I would certainly like to hear from some of you. I have been up and down the West Coast until I have completely lost track of you. Olga Ehlke Stephenson, 1937 S.W. 11th Ave., Portland, Ore.

SPARKS MEMORIAL HOSPITAL: (Fort Smith, Ark.) Will all graduates of this hospital send me their addresses, and news of their whereabouts, for alumnae records? Thanks! Edythe Plyler, Fort Smith, Ark.

CAMP UPTON NURSES: I'd like to hear from all R.N.'s who were in service during the World War at Camp Upton. The old gang wants to see you, or hear from you. We're going to have a reunion. Dr. David Coyne, 600 Washington St., Hoboken, N.J.

HOLDER FOR SCISSORS

Scissors can be made more accessible by sewing, just above your uniform pocket, loop fashion, a narrow piece of tape about one inch long. This keeps the scissors from slipping to the bottom of the pocket, causing it to bulge and wear out. A tape sewed parallel to the side seam makes another type loop into which scissors may be slipped and held firmly. —M. C. Jorgensen, R.N., Chicago, Ill.

TOO MUCH SYMPATHY

"Most of us have some need to 'mother' our patients, especially when they are ill or in difficulty . . . The over-solicitous bedside nurse can retard the convalescence of her patient because of her need to baby him . . . The very helplessness of the sick patient turns him from his mature goal and temporarily heads him back toward infancy. If the nurse unthinkingly takes advantage of his helplessness to overmother him and over-sympathize with him, his return to the time when he can take up his responsibilities may be retarded." —Ruth Gilbert, R.N. "The Public Health Nurse and Her Patient." The Commonwealth Fund, 1940.

MORE PLANES! More trained men to fly them! And an equally important national need is greater physical fitness, supported by proper diet.

AND BREAD IS ONE OF THE BEST SOURCES OF FOOD-ENERGY

A HEALTH BULWARK for America is one of the most important aims of our drive to increase national strength.

More planes? More ships? Yes! But—just as important—a well-balanced, nourishing diet for every man, woman and child.

Of the foods which supply energy needed for fitness, one of the best and cheapest is bread—the delicious, nourishing loaf made by the modern baker. Bread or toast is easily digested and releases a good flow of food-energy that lasts over a period of hours. Also, bread made by the usual milk formula contributes high-quality protein for tissue building and growth, as well as valuable minerals, including calcium and phosphorus.

THE GOOD BREAD made by modern bakers contains both easily digested carbohydrate and high-quality protein—in almost ideal proportions.

In these days of ever-increasing activity, bread—so delicious, economical and easily digested—is one of our most valuable sources of needed food-energy.

For further information about Bread, write to the Department of Nutrition, American Institute of Baking, 10 Rockefeller Plaza, New York, N. Y.

Soy-

AN ECONOMICAL FOOD

Your "preparedness quotient" should include knowledge of cheap and nourishing foods. This article on soybeans is the first of a series to keep you up-to-date on nutrition facts.

BY HELEN MORGAN

• Recently a cartoon, inspired by the national automobile show, showed a man pointing to a car and remarking reverently, "I hear it's made entirely of soybeans."

The observation epitomizes the bewilderment of a public which has, for the past several years, been startled by headlines like: "Meringue from Soybeans;" "Cloth from Soybeans;" "Fenders from Soybeans;" "Varnishes from Soybeans." Last year eight million American acres were planted to soybeans, as compared to a few thousand acres fifteen years ago. A bumper crop of nearly ninety million bushels gave soybeans a pit of their own beside the corn pit at the Chicago Board of Trade, skyrocketed them from an experiment to a full-fledged farm crop worth a hundred million dollars.

The légume that can be whipped up into an automobile is much more appetizing than it sounds. The soybean has a pleasant nutty flavor and is remarkably nutritious. Although soy is apparently "just another bean," it contains practically no starch. It is rich in fats and proteins—which are the most expensive foods and, therefore, those first omitted when incomes shrink. Add fruits and leafy vegetables, to supply more vitamins and minerals, and you have a balanced diet similar to that which has kept the Chinese—who have no dairy products and little meat—physically sound for centuries.

Chinese farmers say there are about a thousand varieties of the soybean. Forty are now grown in the United States, of which six are fit for human consumption. Beans from these crops have provided food manufacturers with flour, vegetable shortening, flavoring, and an assortment of other nutritious items. Manufacturers, far ahead of American families in adopting the bean, have included its products in bread, cocktail crackers, sausages, and candy. Bread for diabetics has been made with soy flour; soy milk promises to become a recognized product for the artificial feeding of infants.

Most accounts of the soybean tend to become slightly delirious with praise. Oft quoted is a report of the United States Department of Agriculture that, "as an *economical* source of wholesome dietary elements, the soybean has no peer." The word to be noted here is "economical." While there may be foods more palatable to Americans, and foods

with wider nutrition value, no other food offers so much for so little money. In the average home, soybeans could provide a flavorsome and healthful variation for the family menu. But among poorer groups (especially those who subsist largely on starchy diets of rice, macaroni, and ordinary beans), the soybean should become an almost indispensable supplement.

Briefly, its average composition is 40 per cent protein, 20 per cent fat, with "traces" of starch—giving soy a higher percentage of protein than any other food except dried eggwhite. According to A. A. Horvath, its protein supplies "all the essential amino acids." Horvath is a recognized authority, having directed soy research in China for the Rockefeller Foundation and now being engaged in studies at the Agricultural Experiment Station, Newark, Delaware.

Soy contains calcium, phosphorus, iron, a large amount of Vitamin A and of the valuable B complex, a fair supply of Vitamins D, E, and K. Since it has less calcium (and some other minerals) than milk, calcium salts and table salts are often added to soy milk. Soy contains iron (which milk doesn't) and more magnesium than cow's milk. About the same amount of Vitamin A is present in cow's milk and soy, but soy provides more Vitamin B_1 and B_2.

Green soybeans are shelled and boiled, just like limas, and often served with soy sauce. The pods are tough and should be soaked in hot water about ten minutes before shelling. Since these beans are not widely marketed, families in suburbs or rural districts might raise them for their own use. They are easily grown and full directions may be obtained from the U.S. Department of Agriculture, Washington, D.C.

There is a black bean, too, which is nice for soup. But the yellow bean, which is usually dried, is commonest. It can be cooked as other beans are. Or it can be made into milk or flour. Dried soybeans and soy products may usually be found in the grocery sections of department stores, in health-food stores, or in foreign districts of cities. Soy milk may be made at home, if desired.

Soy milk may be used in cooking and baking in the same proportions as ordinary milk. When drinking it as a beverage, the Chinese add a little sugar. A little vanilla or other flavoring will increase its palatability. Soy milk may be made from finely ground soybean flour, or by crushing or grinding dried beans which have been soaked a few hours. Boil one cup bean mash in three cups of water for thirty minutes. A milky emulsion will form which should be strained through a cloth or fine sieve. Curd, or tofu, called by the Chinese "meat without the bones," is made by adding magnesium or calcium salts, or rennet or lactic acid to hot soy milk. Protein is precipitated, forming a grayish white curd. This curd is drained and pressed. It is made fresh daily by the Chinese and can be found in Chinese markets in large cities.

The role of soy milk in the artificial feeding of infants should be of special interest to nurses. Most investigators have found it satisfactory, but one of the most comprehensive investigations (recently completed by Helen MacKay at Queens Hospital for Children in London), indicates that a mixture of milk and soy milk is preferable. Tests for nineteen months were conducted with 150 babies who had been brought to the clinic for various complaints. One group was given "the best diet the author could devise," consisting of dried milk with iron, sugar, orange juice, and cod-liver oil emulsion; the remaining numbers were given a solution of full-cream powdered milk and soy milk, mixed in equal quantities, plus sugar, orange juice, and cod-liver oil emulsion. The author concluded that bone calcification was satisfactory in both groups; that the iron in soy milk didn't entirely prevent nutritional anemia, but that it afforded much greater protection

than cow's milk to which no iron is added. Soy milk, she reported, is well tolerated, providing the baby's introduction to it is gradual, extending over a week. For school children, it was recommended, cow's milk would be preferable. Lacking cow's milk, a mixture of half soy and half milk would be the next best alternative.

The soybean is a remarkable understudy for meat—unique because it is within the price range of the very people who need a substitute. It has more than twice the protein of beef, and about an equal amount of fat. Its iron is 60 per cent available—which is about equal to the availability of iron in beef liver.

Soybeans are best when soaked about three hours before cooking—and they will cook more quickly if the soaked beans are ground. Whole beans should be boiled in salted water about two hours, or until tender. Women preparing food for poor families should be taught to cook ground soybeans and rice together, either in equal proportion or by using ⅓ cup soybeans to ⅔ cup rice in one cup of water. If the soybeans are boiled whole with the rice, use two cups of water to a fifty-fifty mixture. To combine with macaroni, mix one cup boiled soybeans with one cup of cooked macaroni—or make alternate layers of each—and make for thirty minutes. To this may be added cheese, tomato sauce, or any other sauce and seasoning customarily favored.

Excellent and nourishing soups can be made of soybeans. For a particularly wholesome soup, combine one cup ground boiled beans with one cup meat or vegetable stock. Sauté an onion in butter, add bean mixture, outer lettuce and celery leaves, and one stalk chopped celery. Simmer at least an hour. Strain and add two cups of milk. Serve.

[*Continued on page* 44]

PROBIE

"Tastes like a new dietitian."

New DEVELOPMENTS IN

• Of 1,387,897 deaths reported in the United States in 1939, pneumonia was the cause of 99,097! This staggering total has spurred scientists on to intensive study of the disease and even in the past year great strides have been made. Today, by judicious use of a combination of serum, oxygen, and drugs the death rate is being reduced.

What pneumonia is.—All pneumonias (there are some thirty-odd known types) are infectious fevers with a focus of infection in the lungs. Development of pneumonia is always evidence of lowered resistance, either general or local. Resistance may be lowered by chilling, irritating fumes or dust, or aspiration of foreign bodies. Chilling is the most common. Pneumonia is most prevalent during Fall, Winter, and Spring, for in these seasons people are most frequently chilled by rapid changes in temperature.

Pneumonia can be spread by droplet infection, which is favored by crowded living conditions. Injuries to the upper abdomen and chest, or any condition affecting deep respiration, may be a predisposing cause. Postoperative pneumonia may be due to one of these factors.

Pneumococci cause about 86 per cent of lobar pneumonias in adults and 54 per cent in children. Streptococci cause more incidence at the extremes of life. Staphylococci and Friedländer's bacillus are other important causative agents. Pneumonia may occur in tuberculosis, pertussis, diphtheria, etc., as complications of those diseases. (For a general discussion of pneumonia, see R.N., September 1938 issue.)

Nursing care.—Most pneumonia cases suffer sudden onset of chill followed by fever, pain in chest, cough, and rapid respiration. Children rarely have chills, but may suffer vomiting and convulsions at the onset.

Isolation technique of nursing should

In pneumococcus typing, the technician places with a platinum loop a fleck of sputum on a glass slide, mixes with it four times as much stained typing fluid. Slides are examined later under the oil immersion lens of a good microscope.

be followed in even the suspected case. Rest and quiet, both physical and mental, are absolutely essential. Nursing care is of the utmost importance and should never be overlooked in the light of newer therapeutic methods. Despite advances in fighting this major disease, general care of the patient is still of paramount importance. The nurse is the commanding officer of that phase of treatment.

Abundance of fresh air (but no drafts) and sunshine is advisable. Coverings should not be too heavy but just sufficient for warmth. The patient should be turned occasionally (especially in the senile type) to prevent hypostatic congestion of the lungs. He should be handled gently and never permitted to turn himself. In cases of dyspnea, the patient may be propped up to an almost sitting position.

Generous quantities of water should be given, if possible by mouth, or (when delirium is present) normal saline may be given by rectum or subcutaneously at regular intervals. Sodium chloride is usually administered liberally; pneumonia patients almost always have a chloride deficiency.

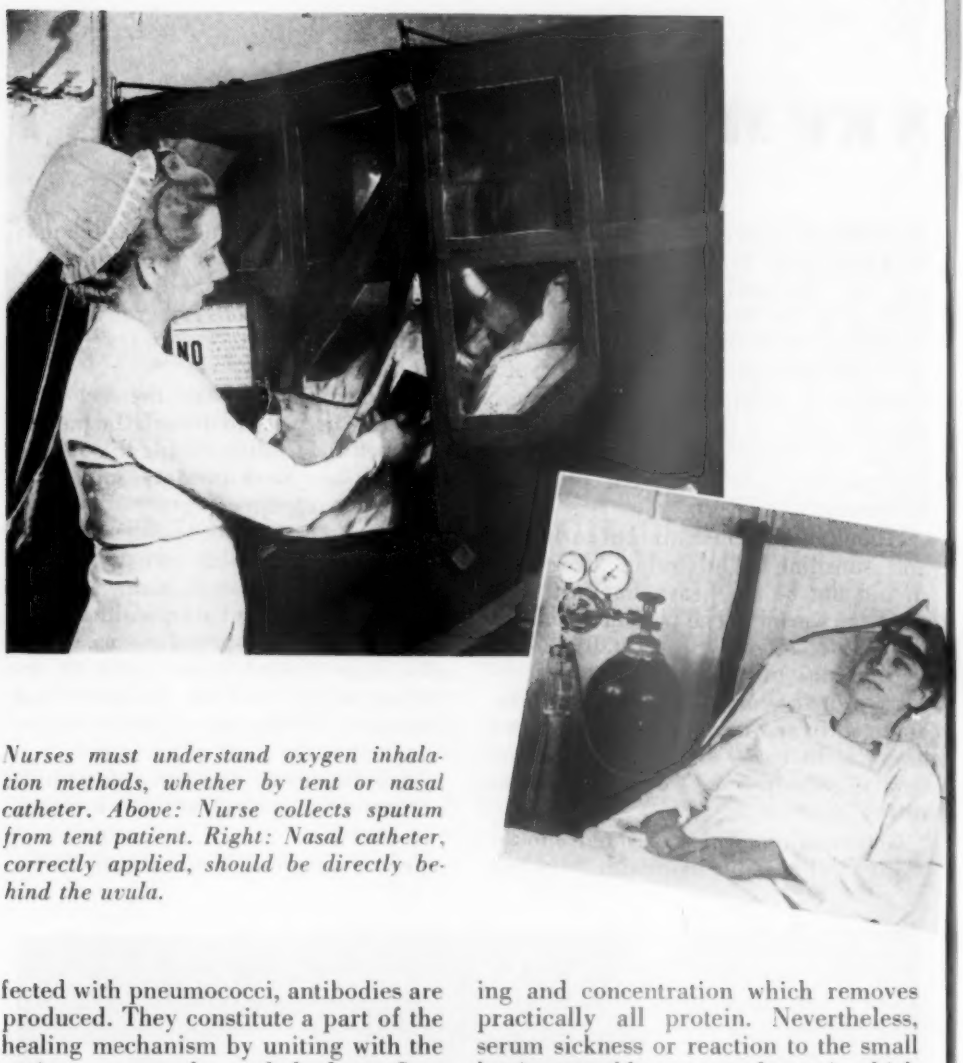
During the acute state the diet is liquid. It is not wise to disturb the patient too much for feeding during this period as nutritious food is more important during convalescence.

Chemotherapy and serotherapy are used together if both are available. Good results have been obtained by use of serum alone, and drugs alone; but by far the most impressive success results from a combination of both according to the wish of the individual physician. Of the two methods serum treatment is the most expensive.

As a diagnostic and therapeutic aid, X-rays of the patient are taken whenever possible.

Serotherapy.—When a body is in-

If no pneumococci are found, some of the sputum is drawn into a syringe and injected into the peritoneal cavity of a mouse. Next day the fluid is typed. Pneumococci can usually be found in quantities large enough for identification.



Nurses must understand oxygen inhalation methods, whether by tent or nasal catheter. Above: Nurse collects sputum from tent patient. Right: Nasal catheter, correctly applied, should be directly behind the uvula.

fected with pneumococci, antibodies are produced. They constitute a part of the healing mechanism by uniting with the antigen or capsular carbohydrate. Specific antibodies for each type of pneumococcus sensitize the pneumococci so that they are destroyed by phagocytosis. When more of these specific antibodies are present than the antigen which induced them, recovery usually follows. By administering serum these antibodies are increased, thus shortening healing time.

Antibodies are produced in the blood serum of horses or rabbits which have acquired an active immunity to the disease. Horse serum is subjected to refining and concentration which removes practically all protein. Nevertheless, serum sickness or reaction to the small but inseparable amount of protein which remains, may occur. Rabbit serum is processed by heating and adsorption with kaolin. It is preferred by many physicians because they feel that fewer undesirable reactions may result, especially if preceded by acetylsalicylic acid. The antibody of rabbit serum is smaller and is believed to penetrate more easily into tissues and membranes. However, it seems advisable to have both serums available for cases showing an allergic reaction to one or the other.

To guard against the allergic reac-

tions caused by the foreign protein in the serum, a conjunctival test or intradermal test is made with the serum immediately before administering it to the patient. If the patient is sensitive to horse serum he must be desensitized. The doctor accomplishes this by first giving very small doses of serum, gradually increasing them at short intervals until the regular dosage amount has been given. Serum is most efficacious when given early in the course of treatment.

Typing.—Typing is the process of identifying the invading micro-organism; only by determination of its character can the correct serum be found. Therefore, extreme care in typing is most important. Serum is specific for the infecting type. Unless the antibody is specific to the type present, successful results cannot be expected. Some types, such as pneumococcus Type 3, which produces large amounts of antibody, are resistant to serum. Specimens of sputum which are collected improperly, secretions from the upper respiratory passages rather than the lung, or choice of wrong organism when two are present are factors that may hinder accurate typing results.

If, in attempting to type a sputum, no pneumococci are found, then some of the sputum is drawn up into a syringe and injected into the peritoneal cavity of a mouse. Twelve to twenty-four hours later the fluid is typed and pneumococci can usually be found in sufficient numbers for typing.

Ample amounts of serum must be given so that the carbohydrate is completely inactivated. Insufficient dosage, or delay until the organisms are so great in number that the amount of serum introduced cannot take care of them, may result in failure. Serum therapy may also fail in the presence of degeneration of the heart, liver, or kidney. This is probably due to the already tremendous load on the body. The breaking point is reached before serum or any other form of therapy can exert its influence. Fatal pressure may also result from exudate, as in the case of meningitis.

Dosage.—Dosage is difficult to determine as the number of organisms present may vary. Virulence may differ, duration of disease is variable, and many other conditions must be taken into account. One authority suggests 100,000 units as necessary to effect a cure in the adult *if treated in time and not of too severe involvement.* This amount is based on the fact that the average person has 10 liters of blood; if these 100,000 units of serum are diluted in 10,000 c.c. of blood there will be 10 units to each c.c. However, some patients require a great deal more than others. This applies especially in cases of involvement of more than one lobe of the lung, in alcoholism, pregnancy, or duration of the disease for three days before treatment. Only constant care and close observation of reactions can determine the more definite amounts necessary. Pulse rate and temperature drops are taken as signs that a sufficient amount of the serum has been injected. The serum is given intravenously to adults and intramuscularly to infants. The latter procedure requires about the same amount due to loss occasioned through the muscle.

Chemotherapy.—The ideal chemotherapeutic agent is one capable of inhibiting the functions of invading micro-organisms or of neutralizing its products. By its action it is able to terminate the disease with no toxic effects to the host. Original work to discover such an agent proved unsuccessful because the amounts needed to affect the organism resulted in harm to the patient.

In 1935, a sulfonamide compound was used by Domagk in the treatment of hemolytic streptococcus. This led to the use of related products. The first was sulfanilamide, a white, slightly bitter, crystalline substance from coal tar, (para-amino- [*Continued on page* 48]

Speech! Speech!

Nowadays it's a civic duty for nurses to make speeches. What with defense activities and Red Cross enrollments, we've lots to talk about. . .Here's advice on how to cultivate an effective platform manner.

BY MONA HULL, R.N.

● "I can't, I can't. You know I can't," wailed Lizzie. "How could I? I haven't time—I don't know enough— Besides, I can't make speeches!" You'd have thought she was working up to at least a Second Inaugural Address; but she was only having her usual jitters before a ward-report to the hospital committee.

That's Lizzie (and many of the rest of us) all over. We are whirlwinds in the locker room . . . and wallflowers on the platform. When asked to "say a few words," our tongues cleave to the roofs of our mouths. We emit a series of strangled squeaks and sit down in a confusion of blushes.

The truth is, however, that most of us—when we gather ourselves together and throw our complexes out the window—have the makings of good public speakers. Whether to our own profession or to outsiders, we generally have something to say. After all, we are noted for efficiency in far more difficult fields. And nowadays our opportunities for making ourselves heard are numerous.

Whether your particular audience is a Red Cross First-Aid Class, an alumnae meeting, or a group of innocent young things who want to know, "How can I become a nurse?"—the technique of putting across a good speech is still the same. The rules are simple, the practice (almost) painless, and the results glowingly gratifying. Once you have the knack, you'll go around looking for speeches to be made, and you will take infinite pride in this new addition to your professional equipment.

The most important part of any speech is the way *you* feel about it. Actually, speech-making is nothing but conversation—with more than a handful of people. You shouldn't feel nearly as panicky on a platform as in a small group discussion. You prepared your facts beforehand, and your audience seldom has a chance to talk back.

This sense of confidence—nay, even of rather snooty superiority, toward

your listeners—is a good sign and should be cultivated. Winston Churchill, now one of the world's great orators, was nervous and uncertain when he made public addresses as a youth. He overcame his difficulties by looking out over his audience before beginning to talk and saying to himself, "What a stupid lot!" Try it; it works!

Ever since the demise of flowery oratory, the vital feature of any speech is what you say—its content. If its content is thin, the speech should not be made. A particularly successful hospital supervisor tells us that her rule for speaking is simply, "Have something to say; say it; sit down." (This philosophy might well be adopted for conventions and district meetings, too!)

The "something" you have to say in nursing, luckily, is usually practical, factual, and easy to organize. The Greeks, who were distinguished public speakers centuries ago, held that a good speech should have a brisk beginning, a solid middle, and a definite end. If you outline your subject according to this rule you won't wander aimlessly from idea to idea. A good stunt is to put all your facts, item by item, on separate 3 x 5 inch cards. Then rearrange the cards until you've found the most interesting and logical order. There's your solid middle. Next plan your introduction and wind-up. Transfer the whole to one small sheet of paper and you have your finished outline.

Write out the whole speech if you feel insecure when you look at the outline. But *don't* read it! The written speech should fix whole sentences in your mind, help you over the hurdle of expressing a difficult point effectively. Papers read word for word (usually in a dull, disinterested voice) are the bane of an audience's existence. They should be unconstitutional.

R.N.'s who do a good deal of prepared speaking at district and State meetings, tell us of a trick they use. They memorize cold, the first three sentences of the

introduction and any stories to be told. They use a complete outline on small cards, refer to it unashamedly for figures and chapter headings. They also learn by heart the closing bright remarks so that they don't suddenly come to a full stop with a "that's all" look. They claim that by the time you're smoothly over the opening the audience has settled down, your first qualms have vanished, and the rest of your material springs to mind easily, helped along by your little set of cards.

A word about beginnings. Don't tell a joke—unless it is so obviously apropos that it forces itself on you.

A good beginning can always be made by some reference to the particular interests of the audience—business if they are business men, home and families if they are club women, for instance. Because most people are consistently interested in themselves, this approach is almost foolproof. Avoid such banalities as, "It gives me great pleasure to be able to be with you today," and, "When your chairman asked me to address you I assured her that there were any *number* of other people who could do much better than I . . ." Would *you* be intrigued by anyone who started off that way? Try questions for an opening, or a curiosity-arousing statement of a problem. Put aside your favorite quotations. [*Turn the page*]

In the body of your speech, use anecdotes to illustrate your points—but only when they are appropriate. Give figures as necessary—but keep them simple and dramatic. Substitute a one-syllable word for longer ones whenever possible. Be friendly and intimate. (A sure way to win the group's sympathy!)

Your conclusion should be swift and merciful. It should manage to sum up without reviewing and to leave the audience with the impression that you've delivered a last good blow. Above all, don't say "In conclusion———" any more than five minutes before you actually finish. Better still, don't say it at all.

Be confident. Audiences never know as much about your subject as you do!

What about platform manner? The most delightful speakers are those who have no conscious platform manner. They are so at ease before an audience that it is never necessary for them to adopt the smirks and gestures of the amateur. Safe advice is to stand, sit, and move on the platform just as you would in any public situation. Be as unaware of yourself as possible. Look right at your audience, when you speak, and try to avoid fixing your eyes on the clock or the ceiling.

Inconspicuous (but not dull!) clothes create the best effect. Dark, simple suits and dresses with bright touches are always successful. Wear a hat which will show your face but won't daze the audience with its peculiarities.

Once on the platform and nicely settled, it's a good idea to try to rest in peace until your turn to speak arrives. When the chairman says, "And *now* it is my pleasure...," organize your approach. Walk slowly to the lecture stand and be positively leisurely about arranging your notes and yourself before you emit your first learned sentences. A trick of old-timers is to stand a moment and look over the audience once before starting your talk. Very effective!

Don't worry too much about your voice. In this day of microphones and amplifiers, it is almost never necessary to screech. The female voice carries best when it is pitched low; good diction is more important than high volume—which usually produces only a shrillness unpleasant to the ear.

If you feel a little breathless as you go along, stop at the end of a sentence and take a big breath. Pauses make for a good effect, frequently emphasizing the point you have just made. Speak slowly to give each of your facts a chance to sink in. When you realize you have said all you meant to say, don't turn back even if you've finished earlier than expected. Tack on your prepared ending neatly, finish off with a zip, pick up your notes from the table, and sit down. The audience will do the rest.

Here are some facts on several special kinds of talks which you may be called on to give:

THE INTRODUCTION. This should be the briefest of brief speeches, as the audience hasn't come to hear you anyhow. It shouldn't be either a life history or a eulogy of the subject who is to follow. Personal stories are fine here, a good lead being "The first time I ever met our speaker of the evening," and so forth. Above all, no oratory, long jokes, or lecturing on your part.

THE REPORT. One of the most frequent speeches [*Continued on page* 52]

IN REVIEW

A QUICK GUIDE TO CURRENT BOOKS OF INTEREST TO NURSES

TEXTBOOK OF SURGICAL NURSING.

Henry S. Brookes, Jr., M.D. *and Pearl Castile*, R.N. $3.50. *The C. V. Mosby Co.* (*Second Edition.*)

● This book seems to use a rather older approach to the subject of caring for surgical patients. It deals at length with diagnoses and operative procedures, and incidentally with nursing techniques.

The chapter on instrument setups for a variety of operations seems long and unnecessarily complex for students. Post-operative complications are discussed from the doctor's point of view. But such important post-operative manifestations as pain are passed over in a few words.

The reader is disappointed to find little information about the dramatic new advances being made in the surgery of wounds. However, such factual material as there is, is accurate and logically presented. An enormous amount of information has been put into six hundred pages.

PROFESSIONAL ADJUSTMENTS NOTEBOOK FOR FIRST YEAR STUDENTS OF NURSING.

Elizabeth M. Jamieson, R.N. *and Mary Sewell*, R.N. $1.25. *J. B. Lippincott Co.*, (*Third Edition.*)

● This loose-leaf collection of little lectures for students used to be called "Ethics Notebook for Nurses." Presumably the authors, wishing to make a fresh start, changed the title. The only suggestion of this reviewer is that they should try again.

If the object of these pages is to "build character in nurses" one cannot see how it can succeed. Its style is so ponderous, its approach so preachy, and its morals so vague that one is left more bored than thoughtful.

Of necessity, this is a difficult subject to deal with in print. But need the authors have written the chapter oddly headed "Romance?" And need they (in the style of the Gay Nineties) have advised R.N.'s to "avoid the magnetic salesman, and invest with deliberation"?

It is a serious question whether any sort of "good adjustment to life" can be taught out of notebooks. But even as a guide, this attempt is not appealing.

TEXTBOOK OF PHARMACOLOGY FOR NURSES.

Margene O. Faddis, R.N. *and Joseph M. Hayman*, M.D. $3.00. *J. B. Lippincott Co.*

● In this text, one of the snag-points in everyone's nursing knowledge is ably dealt with. Miss Faddis actually teaches pharmacology, and knows how to present its knottier angles simply.

Evidence of the authors' practical outlook are the sections on the costs of various drugs and pieces of equipment, on the modern drug store and its problems, on diseases as they relate to drugs. Useful also for the graduate reader are the suggestions on where to go for newest drug information.

This book will certainly find uses far beyond its design as an undergraduate text. For refresher courses and personal libraries, it may be recommended.

THE ANATOMY OF THE CAT

Richard R. Stuart, PH.D. $.50. *Denoyer-Geppert Co.*

● Intended as a teaching aid to all anatomy students, this series of scientific drawings attacks its subject in much more detail than nursing texts allow.

Perhaps, for the ordinary undergraduate nurse, who wants to know only enough anatomy to pass State boards, the amount of loving elaboration would be too much. But for R.N.'s who specialize in, or teach anatomy, the scientific neatness, and workmanlike artistry of this book will be irresistible.

The price is so modest as to be within the reach of anyone. There is no text, but careful indexing has made this unnecessary.

RN

ORGANIZATION for INDUSTRY?

• As R.N. predicted last December, increased concern over industrial health has already turned the national spotlight on nurses in that field. Last month other professional magazines took up the cry, devoted major space to the importance of industrial nurses.

One point which has not emerged for discussion—apparently not even among the industrial nurses themselves—is the possibility of a national organization for this special branch of the profession, a National Association of Industrial Nurses. . .

R.N. believes some nationwide organization is needed to protect the interests of this group.

In some States, industrial nurses are organized in sections of the State nurses' associations; in others, they affiliate with the public-health association. But as yet there is no national body tying together and guiding the aims and objectives of all sectional divisions. There is no clearing house through which opinions and factual information may be distributed. There is no conference table at which industrial nurses from all parts of the country may discuss current problems and needs. There is no strong, central unit to guide and defend the principles of this branch of nursing; no board experienced in establishing standards.

The same predicament is also true of other minority groups in

nursing. But in industry, it seems to us, the need for well-knit organization is more urgent. Thousands of nurses will enter this field in the coming years. Hundreds of thousands of factory workers will depend on them for a large portion of all the health and hygiene supervision these workers will receive. . .It is therefore imperative that every possible step be taken to make industrial nursing one of the top-ranking branches of the profession.

R.N. recommends that if a national organization is formed, it be developed by industrial nurses, for industrial nurses.

Other nursing organizations have eyed this field hopefully, even casting out lines suggesting their willingness to "take industrial nurses in" or to do their organizing for them. Such a move at this time would suggest a lost opportunity for industrial nursing. The privilege of setting the pace for a comparatively new and rapidly growing branch of the profession is not one to be tossed aside lightly. It should go to those who know the requirements of industry by actual experience, to those whose knowledge is practical rather than theoretical.

The only experts on industrial nursing are industrial nurses. They alone can determine the needs of industrial health and set standards accordingly. We hope they will do so. It may take unusual initiative now, but in the long run it will pay rich rewards in stability of service and security of jobs in this highly specialized field.

SISTER MAGDALENE, R.N.

• Next month is a golden anniversary for Sister Magdalene of St. Louis. For, exactly fifty years ago, as a slender, shy, red-headed country girl, she left the tiny hamlet of Tower Hill, Illinois, and marched on the city of St. Louis, Missouri.

All the hustle and bustle of a thriving cotton town in the Gay Nineties could not confuse one issue in Catherine Magdalene Gerhold's mind, however; she had come to St. Louis to be a nurse. A nurse she became, and a nurse she still is today, rounding out half a century in the profession in April.

Catherine Gerhold was nineteen when she went to the city fifty years ago, knowing nothing of nursing, administration, or finance. Today she has reached the pinnacle of administrative posts open to nurses, is fiscal superintendent of the handsome Deaconess Hospital in St. Louis, doing much of the buying for the institution and all of its banking business. For nearly forty years she was Sister Superior of the hospital, in charge of all other nurses. The girl from Tower Hill traveled a long way, found what she sought, and has kept it a long time.

When she went to the hospital in 1891, Sister Magdalene, as she is known in the Evangelical order, the stately building which now adorns Oakland

Avenue, on the edge of Forest Park, was not yet built. The hospital was housed in an old residence at 2119 Eugenia Street, in unfashionable South St. Louis. This institution, as she recalls it, was something to remember.

"Nursing could hardly be called a profession in those days," she remembers. "We scrubbed floors instead of studying anatomy. And this hospital fitted perfectly into such a picture. If we had a surgical operation, we had to rig up the operating apparatus around the patient's bed. The only room which could be called an operating room was one which was used for eye cases by Dr. A. E. Ewing and Dr. John Green, who later became staunch supporters of the institution."

In this place Sister Magdalene served a year's hard probation in her training. Such was her industry that she was rewarded in her fifth year with the position of Sister Superior, a post she held for thirty-nine years.

Reviewing the changes which have taken place in nursing between that time and this, Sister Magdalene is most forcibly struck by the alterations made in operating routine. Antisepsis was practiced, but in a considerably less meticulous fashion; a pair of bare hands and arms, thoroughly washed in soap and water, was regarded as completely sterile. Gowns, masks, and sterile gloves were unheard of. Steam sterilizers for instruments were concealed in the future and boiling was the answer to this problem.

"The patient, too, went through a different routine," she recalls. "For an abdominal operation, the patient had to enter the hospital three days in advance. We treated him first with calomel, then with epsom salts, causing almost complete dehydration. For twenty-four hours he didn't get a drop of water; there was no glucose in those days.

"Then the portion of the body to be operated was liberally lathered with soap, which was left on overnight. The next day we cleaned it off with bichloride, and then scrubbed vigorously with a stiff brush. By this time the patient was probably pretty clean, but his stomach was also sore, and the raw skin left by the brush was very likely to produce ulcers when the stitches were put in.

"I never see the neatly arranged row of instruments, sponges and bandages laid out for an operation today without thinking of our equipment then. We didn't have to number our sponges; we only used two. Sea sponges, they were, and when we were through with them, we put them in a solution to keep them ready for the next operation.

"Water purification is another development that we lacked in the old days," she continued. "We did use boiled water in the operating room, and we had filters for drinking water. But filters didn't take out typhoid germs, and we frequently had some typhoid cases around. Now, with chemical purification of water, we have none."

When the two original deaconesses started the hospital, they did it on less than the proverbial shoe-string. In fact, a good stout shoe-string would have been welcomed. Their initial capital for the commissary department was fifty cents. With view to getting as much as possible for their money, they spent fifteen of their pennies on a huge soup bone, and hoarded the remaining thirty-five cents. Despite this humble start, the nursing and religious order had attracted eleven more deaconess-nurses within three years, and patients had increased proportionately, necessitating larger quarters.

In 1892, a year after Sister Magdalene joined the Order, a small hospital and nurses' home was built at the corner of Belle and Sara Streets, where the Order remained until 1930. In that year, the finances of the institution having flourished under thrifty administration, the [*Continued on page* 40]

'WHERE THERE'S A

Cousin Bessie

● "But you ought to make a will. Every nurse over twenty-one should," Joe said earnestly. Joe has just passed his law examinations and is weighted down with legal knowledge and "whereases" and "hereinafters."

"Don't be silly," I scoffed. "In the first place, I haven't the faintest intention of dying, and in the second place all my worldly possessions could be carted around in a knitting bag."

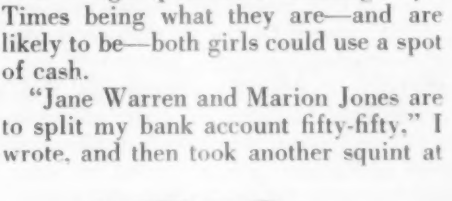
"Uh-huh," Joe said skeptically. "No bank account? No jewelry—such as these?" He touched the lovely old bracelet and ear rings that had been my great-grandmother's and which I loved so dearly. "By the way, who's your next of kin?"

That's when he won the battle—because my "next of kin" is Cousin Bessie. Bessie is the stingiest woman I've ever known. She's the type that expects a set of dishes free when she buys a loaf of bread, and she wants her money refunded at the box office when she doesn't win the jackpot at Screeno. Few as my belongings are, I'll do everything in my power to prevent their falling into Bessie's hands!

So the next night I sat down with the stub of a pencil and a pad of paper. "To Whom It May Concern" looked very impressive and legal at the top of the page.

"I hereby give and bequeath" didn't have much oomph, but it sounded logical and I wrote it down, and then I was stymied. *What* did I have to give and bequeath? My only comparatively valuable asset was my bank account, which would never cause lumps of envy in J. P. Morgan's breast. "But I won't see it go to dear Bessie, or to the Fund for Civic Improvement, or the League of Poison Ivy Fanciers," I thought. Finally my choice narrowed down to two people—Jane, who has been my closest friend since the days when we checked up on that Santa Claus business and found it was just a lot of horseradish, and Marion, who has seen me over some rough spots since training days. Times being what they are—and are likely to be—both girls could use a spot of cash.

"Jane Warren and Marion Jones are to split my bank account fifty-fifty," I wrote, and then took another squint at



"Then I was stymied. . .what did I have to give and bequeath?"

WILL—'

BY ROXANN

"'Now comes the tough part,' said Joe. 'Can you prove that you're of sound mind?' I tossed a book lightly . . ."

it. No, that would never do; it sounded like a couple of crooks divvying up the loot. I began again.

"I hereby give and bequeath to my dear friends Jane Warren and Marion Jones my bank account, to share and share alike." I was pretty proud of that phrasing!

Real estate? Huh! That was easy. Who wanted the geranium and the fern in my window?

Next came the problem of jewels, not much of a problem really, but a little more serious than the real-estate angle. First, there were the family heirlooms —not numerous, but beautiful in their old settings. After them came the ring Mother and Dad had given me at graduation, and the pearls I had bought for myself—lovely examples of Japanese culture at $9.95. Cousin Bessie's daughter Sarah, a pretty, wistful-eyed child, had fingered those phony beads longingly the last time we met.

I knew that if Cousin Bessie had anything to do with it, Sarah would be a study in lavendar and old lace before she owned even a string of Woolworth's best. I made a mental note to send Sarah some pearls of her own when she finished high school. But, just in case I cashed in my checks before then, I put a paragraph in my will to the effect that Sarah was to have mine. For good measure I tossed in a nice old square locket and some of the other old jewelry that she was too young to appreciate now, but would treasure later, if I knew Sarah. Plus my feather fan and Spanish shawl. Such fripperies ought to give Cousin Bessie apoplexy, if and when!

I finally got the valuables question settled to my approximate satisfaction. Anyone watching me writing-in and scratching out would have thought I was disposing of the Russian crown jewels!

My books, including some modern first editions, I left to Eloise Mohr. How many times Eloise and I had gone shopping for new clothes and come back with an armful of books instead!

That didn't leave much to worry about except my nursing instruments, my hospital pin, my wardrobe and my beau. Beginning to feel exactly as if I were signing my own death warrant, I wrote: "Whatever remains—my personal possessions, etc.—are to be auctioned off among the nurses at this hospital, and the [*Continued on page* 47]

R.N. GOES TO AN INVENTORY

BY DOROTHY SUTHERLAND

Last month R.N. packed its typewriter and camera, traveled 150 miles to Albany, New York, to record for you an important milestone in the history of nursing. On these pages is the *first* picture-story of the *first* State survey to get under way in the *first* national inventory of nursing resources of all times!

With the mailing of 100,000 questionnaires in December—some 50,000 to graduate registered nurses in active service, and the remainder about evenly divided between inactive R.N.'s and practical nurses—New York State launched the nation's census of nursing. By this time, all other States have also begun inventories; thus, the activities of New York shown here are fairly typical of efforts of nursing associations from coast to coast. National health authorities hope to have the nurs-

ing statistics of all forty-eight States and territories tabulated some time before Summer.

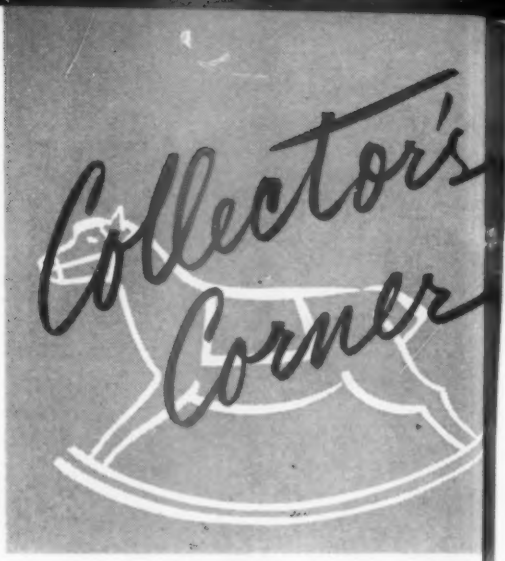
This is the story of New York's survey to date:

To the Albany headquarters of the State nurses' association at 152 Washington Avenue (see illustration number 6), some 35,000 R.N.'s and p.n.'s have already sent their questionnaires. Bag after bag (4) filled with completed forms arrives in each day's mail.

In the executive offices of the association, United States Public Health Service special agent Emily J. Hicks (seated) and her associate Elizabeth Hall (5), examine the questionnaire forms to see whether cooperating nurses are providing complete information.

Questionnaires are next sent down to the clerical department for sorting (8). Here Edith Atkin (3) supervises a staff of twenty-five clerks whose job it is to record on duplicate "Keysort" index cards (2) all the information contained in the questionnaires. When the cards are completely filled in, they are checked for accuracy (1) by specially trained workers. Then, for easy classification, the major topics on each card are punched out (7) by machine.

Like every other State, New York will send the original questionnaire forms to Philadelphia where USPHS officials will direct the gargantuan task of tabulating nationwide statistics. In Albany, the nurses' association will file one copy of its own duplicate card record; the second copy will be sent to each nurse's own district where it will serve as an aid to local health officials. New York State expects to complete its survey by April first.



ROBERTA MATTHEWS, EDITOR

• This department has been going strong ever since it was launched. several months ago. It does seem as though nurses all over the country have hobbies—and every month some new type of collection crops up. No matter how strange your own hobby, readers of this column will want to hear about it and to "swap" choice items with you. So don't hesitate to drop us a line. We'll publish as many letters and requests as space permits.

Readers who sent scrapbook material to Sybil Watson, in Brooklyn, New York, will be interested in this note which she has just sent us. "Your response to my request for material has been so generous," she writes, "that it has been impossible for me to acknowledge individually every package received. I've been snowed under and have enough material to keep me busy in my spare time for the next six months! A thousand thanks!"

Which brings up a little reminder we have been meaning to pass on to you. We think it would be a nice gesture if all nurses receiving collectors' items from other R.N. readers would make a point of acknowledg'ng them. We had a letter the other day which said, rather wistfully, "I sent a couple of china dogs to one of your collectors and rather looked forward to hearing from her. So far there hasn't been a word." A penny postcard is quick and economical.

A great many nurses are collecting pictures and would like to receive any which R.N. readers have to spare. Here are the names of the first six requests received:

Mrs. D. B. Spencer, 7600 Rainier Ave., Seattle, Wash. (Babies, toys, dogs, and kittens in color.)

Dorothy Smith, 615 S. Comilla St., Memphis, Tenn. (Old-time scenes of country fairs, church socials, buggy rides, etc.)

Alice Decker Olsen, 137 Elm St., West Brighton, S.I., N.Y. (Christmas cards especially. Wants to exchange for Indian-head pennies.)

Clara M. Bardell, 104 W. Lewis St., Wichita, Kans. (Scenic postcards from anywhere.)

Mae Mahoney, E. Pleasant St., Walla Walla, Wash. (Holiday greeting cards; postage-paid.)

Beulah Powell, City Memorial Hospital, Winston-Salem, N.C. (Postcards or pictures of hospitals.)

Have any of you collectors unusual pieces in your collection, or anecdotes or experiences to report? Tell us about them in a letter.

Now for this month's batch of special items wanted or offered:

CHINA ZOO: I collect china or glass animals of all sorts, and now have about seventy-five in my "zoo." I'll be glad to help you out on your hobby. Lillian Westphal, Wentworth Military Academy Hospital, Lexington, Mo.

SALT AND PEPPERS. Will other hobbyists send me novelty salt and pepper sets, in exchange for whatever I may send them for their hobby? Vesper Haight, 416 W. 12 St., Oklahoma City, Okla.

BOOTS, BOOTS: I'm interested in small antique glass or china slippers or boots. Am willing to pay for any that you might have to sell. Do other nurses ride this hobby? Charlotte (Mrs. Louis) Stillman, 72-39 139th St., Flushing, N.Y.

GADGETS: Will you help me start a collection of gadgets? I am looking for tiny glass, wood, and china animals, any shape, but small. Thanks for your help. Onita M. Buhrmaster, 66 Bunn Street, Amsterdam, N.Y.

MECHANICAL PENCILS: Who else collects pencils? I like them in odd, unusual designs, or carrying advertisements. Would like to get as many as possible from all States and foreign countries. Will gladly exchange with other hobbyists. Mary Okle Boswell, Penalosa, Kans.

COINS: It is a lot of fun saving coins, and getting a whole series of pennies, nickels, or dimes. I'm still lacking a few dates; will exchange duplicates or correspond with anyone interested. Clarissa W. Haselden, 46 Massachusetts Ave., Cambridge, Mass.

TOOTHPICK HOLDERS: These are my hobby, together with odd cups and saucers. Who wants to exchange? Irene G. Roehl, 123 W. Heron, Aberdeen, Wash.

SALT AND PEPPERS: Antique and modern shakers, shaped as animals, people, flowers, or other objects are my special interest. Wood, china, metal, or any material will do. I would like shakers from every State and will exchange with other collectors. (Mrs.) Edna Falardeau, 5340 St. Paul Blvd., Rochester, N.Y.

HANKIES: Big ones, little ones, any shape, color, or design will be gladly exchanged with anyone on any terms. Maxine Bowles, 1045 North 31st St., Billings, Mont.

CHINA DOGS: I am collecting small ones, and would like to get some from different States. What can I send you? V. W. Taylor, 225 W. Queen St., Hampton, Va.

BOOKS OR CATALOGS: I'm on the look-out for books, on all subjects, catalogs of famous art collections or museums, articles on art, and reproductions of paintings for scrapbooks. I would be glad to hear from hobbyists in other States who may care to exchange or sell. Alma C. Jones, 509 E. 79th St., New York, N.Y.

ASH TRAYS: I would like them from many different places. What are you collecting that I can send you in exchange? (Mrs.) Priscilla H. Morrison, Tucumcari, N. Mex.

MINIATURES: Will pay for, or exchange, any well-made wooden or glass miniatures, one-half to one inch in height. Let me hear from you. Mae E. Brenner, R.3, Lititz, Pa.

CARDS FOR BUTTONS: Will trade scenic cards, stamps, tuberculosis seals, shakers, or match covers for old buttons. I particularly want such old buttons as tintypes, paper weights, fable, or Jenny Lind buttons. E. W. Small, Box 63, Freeport, Maine.

STAMPS: Old and new, from the United States or foreign countries would be appreciated. Let me hear from other stamp gatherers. Florence Casi, 2115 Ave. D., Scottsbluff, Nebr.

CHINESE ART: Do you know of anyone who has available pieces? I also am on the look-out for miniature dogs. Will R.N.'s from other States please write me? Ellene Hiser, 1086 Hunter Ave., Columbus, Ohio.

IRISH SETTERS: Where can I get small models of setters, or other dogs, any size under seven inches? I would appreciate ideas; perhaps I can help someone else with other problems. Kathryn Krom, 67 E. Geopp St., Bethlehem, Pa.

TOY HORSES: My price limit is from ten to fifty cents. I would like to exchange with other hobbyists. Will pay postage. (Mrs.) Mae Anderson, Box 146, Comfrey, Minn.

BELLS: I am another bell-collector. I'd be happy to receive any size or kind. I will acknowledge and pay postage on any contributions. Anna C. Schanz, 402 W. Church St., Marshalltown, Ia.

POSTMARKS: All you need for this hobby is an Atlas and plenty of mail. I've been going strong since 1936. I'd appreciate any samples from any place. Fern R. Nicholson, Sheldon, Ill.

LONDON LETTER

London, January 13, 1941

● Since I last wrote, London—as you know—has passed through an ordeal of fire. It was a night so terrible that the mind shrinks from its memory. Yet, as I looked across the city, the mighty gold cross crowning St. Paul's cathedral triumphantly rose against the morning sky and shone in the morning light as a symbol of renewed hope and courage, a testimony of our faith that

"Behind the dim unknown
Standeth God within the shadow,
Keeping watch above His own . . ."

All day long the air was filled with smoke and the sound of fire bells and hissing water pumps. Perhaps worst of all was the sickening smell of burning which seemed to permeate everywhere; it persisted for days. Walking down Fleet Street, on the way to my office, I stepped over numerous firemen's hose and pools of water. As I stretched to avoid two large streams, a fireman standing by grinned and said, "What a waste, Miss." Only then did I realize that there was a stream of beer flowing beneath the door of a wrecked wine shop. On each side of the street the ruined buildings towered proudly and defiantly as if proclaiming Swinburne's immortal words: "Bear us witness. Come the world against her, England yet shall stand."

I have not seen the desolation that once was Guildhall, preferring to preserve undimmed the memory of its beauty and ancient grandeur. The last time I was in the great hall it was crammed to overflowing with nurses in uniform and girls from the most famous schools in and around London. A nurse recruitment meeting was in progress and the Lord Mayor and other important

personages were there. But excitement became intense when our beloved Queen Mary unexpectedly arrived to help, by her presence, the profession she loves so well. I could not bear to desecrate such a memory by gazing upon a smoking charred ruin.

During that awful night, many hospitals suffered badly. One, centuries old, lost four wards and a new private wing which cost thousands to build. A large fever hospital, hit by high explosive bombs, had to evacuate quickly. One small girl of six was so terrified that, although a tracheotomy had been performed only the day before for diphtheria, she jumped out of bed before the ward sister could stop her. She was found hiding in a cupboard. In her new hospital she is quickly recovering—but no one mentions bombs! Another little victim was much less concerned about the bombs than about the fact that her presents had been lost. Tears turned to smiles when a nurse produced them all.

One day I happened to be in a maternity hospital when the sirens sounded. The nurses at once picked up the babies, wrapped each in a blanket, popped each child into a small zinc bath, and carried it to a place of safety. Thirty babies were out of the ward in three minutes. Mothers who could walk were taken down to the shelters; the rest were laid on mattresses placed under the beds. Needless to say the nursing staff stayed with them.

Down in the shelter I found the sister-tutor with her nursing class. Although study was suspended, I noticed a number of student nurses reading textbooks. One said, "We must pass the exam somehow, blitz or no blitz." The tutor remarked that, while examination work was difficult, the students were doing wonderfully under very trying circumstances. It was quite evident that much of their success could be attributed to the tutor's sympathy and understanding.

Many of the training schools have been evacuated out of the cities to safer areas. In many cases, students from different hospitals are gathered under one roof for training and these are necessarily all at different stages in their studies. The difficulties of such an arrangement—both to tutors and students—can well be imagined. In spite of this there are no grumbles, for by patient acquiescence and cooperation each is rendering valuable service to the country.

Throughout England—from Land's End to John o' Groats, from East to West—nurses are carrying on their duties. Sometimes when the roll is called after a raid there are some who cannot respond. Only this week the matron, medical superintendent, and five nurses remained silent in one hospital; but the work of the hospital will continue. It is the same in the factories and workshops; in first-aid posts and shelters; in large businesses; in the Army,

Navy, and Air Force; in the schools and homes of the people; indeed, wherever nurses are to be found.

Next month I shall hope to tell you something of the work being done by shelter nurses. In the meantime, we are keeping our chins up and preserving a sense of humor. Which reminds me of the story of the nurse rescued from Dunkirk who, having lost all her possessions, saved her best tailored costume by wearing it under her uniform for three days while waiting on the beach to be taken off. The costume now pressed and cleaned seems none the worse for its adventure!—LOIS OAKES, S.R.N.

Sister Magdalene, R. N.

[*Continued from page* 29]

present seven-story building overlooking Forest Park was erected.

Deaconess Hospital today has every modern appliance, even to a $45,000 deep-therapy X-ray machine. The hospital's capacity is 225 beds, designed to accommodate both patients and nurses. Both the Order and the number of patients have again grown beyond the facilities, however. There are now about 150 deaconesses, who live on the third floor of the hospital and in apartments rented for their accommodation in the neighborhood. Plans are already being hopefully made for the construction of a new nurses' home and training school on the hospital's property, in keeping with the modern belief that schools and nurses' homes should be separated from the nurse's scene of duty. The new school is being planned to fully conform to the State's requirements for approved rating.

Sister Magdalene finds the nurse's lot in general vastly improved over the standards of fifty years ago. Nurses were seldom regarded as professional women in those days, she recalls. Hours were anywhere from twelve to twenty-four a day. When a nurse undertook service in a private home, it was expected that she should undertake the housework. That was true in almost all cases, people coming to hospitals only when they were expected to die. Uniforms were uncomfortable and unwieldy, being floor-length dresses, severely buttoned up over corsets, with standing collars and long sleeves. Veiled caps and black ties made the outfit even more cumbersome. These uniforms have given way to short, all-white dresses with long sleeves in the modern tradition.

Sister Magdalene assumed her important administrative duties about ten years ago. She still remains active in the nursing routine, however, and is seen at all hours in the hospital corridors and rooms, giving help and cheering patients. After half a century of it, Sister Magdalene thinks nursing is the greatest of all service careers open to women.

News!

• What's new?

With the defense program and possible sectional nurse shortages looming ahead, topic of the month is "Can we hope for the eight-hour day and better salaries in the near future?"

Up to the present, the eight-hour day continues to make converts with encouraging regularity. A signal victory is being celebrated by the private-duty nurses of Peoria, Illinois. For two years they have been trying to make eight-hour duty compulsory in all three of their city's hospitals. Recently the plan was approved by the medical staffs and is now in effect. R.N.'s receive $5 daily, work eight hours instead of a previous twelve or twenty.

In Oakdale, California, nurses are paid $6 for an eight-hour shift. Top price for the short day was secured through the efforts of the California State Nurses' Association.

Some States still declare that eight-hour schedules are not practical at this time. In Iowa, for instance, the Waterloo Nursing Service Bureau reports that of nearly 4,000 calls 2,329 were for twelve-hour duty, 607 for twenty-hour duty. In Logansport, Indiana, private-duty nurses are now celebrating a reduction in their hours from twenty to twelve. They'll be permitted to take eight-hour cases—if the family or physician insists. But general opinion doubts that such insistence will be immediately overwhelming.

* * *

The Modern Hospital recently surveyed 1,387 hospitals in the United States and Canada; its findings shed some light on nurses' salaries. According to the figures, the average floor-duty nurse earns $109 a month in hospitals with 300 to 499 beds. If the hospital has less than 25 beds, the salary runs around $95. For hospitals of almost all sizes, salaries were highest in the Mountain and Pacific States; next highest in the East; lowest in the South, Midwest, and Canada. Head nurses make an average salary of $138 monthly in large hospitals; $108 in very small ones. (Moral: Be a head nurse, in a large hospital, in California!)

* * *

Off to Army camps have gone hundreds of Red Cross first-reservists; about 4,000 more are to follow. The first enrollee from each town and city never failed to get a round of applause from her community. Among the "firsts" who

are in the Army now are: Nina Pouncey, San Antonio, and Dorothy Hope, McAllen, Texas; Dorothy Frey, Fairbury, Nebraska; Fern Little and Dorothy Luikart, Pueblo, Colorado; Susanna Kauffroth, Near Gap, Pennsylvania; Mildred Nixon, Dayton, Ohio; Dorothy Newberry, Muskegon, Michigan; Mary Willgrube, Springfield, Missouri.

* * *

A slightly sour note, amidst the general rejoicing about Army posts, was injected by the experience of twelve nurses in Monrovia and nearby California cities. They are veterans of the last World War. But as a result of a recent State Supreme Court ruling, they may lose the exemption from property assessments which they have always enjoyed because of their service. . .It seems that the State constitution doesn't mention *women* veterans.

* * *

Nurse shortage is only talk as yet in most areas. But it is a real and unhappy fact in the hill country of Kentucky where the Frontier Nursing Service lost eleven members at one swoop. Their staff was largely made up of English girls who went home when Britain called, leaving 3,000 families without adequate care. The hill-folk won't suffer, however; American R.N.'s will soon fill the vacated posts.

* * *

Eastern industrial nurses' clubs will hold their annual conference next month at the Berkely-Carteret Hotel in Asbury Park, New Jersey. The date is April 26. Interested readers should write the president of the New Jersey Industrial Nurses' Club, hostess group of the conference, for full details. She is Elizabeth Sennewald, 436 East 36th Street, Paterson, N.J.

* * *

New York's nurse practice act has rolled up a record of headaches since its enactment in 1938. Designed to make nursing in New York illegal without a New York State license, the law has never really been enforced because of the slowness of out-of-State nurses to apply for licenses and the slowness of the Department of Education to issue them. A bill is now pending in the Senate which may ease the situation. If it passes, nurses will be given more time to file applications for registration. And the final effective date of the law will be postponed until January 1, 1942. The NYSNA is the sponsor.

* * *

TIDBITS: In Royal Oak, Michigan, an embarrassed school board found that, although it had been hiring nurses for school jobs for fifteen years, a forgotten 1929 ruling made it illegal to do so. R.N.'s may face dismissal—unless someone can think of a way out of the dilemma. . .The new nurses' dining room at Kirby Hospital, Monticello, Illinois, has a magnificent marble fireplace, silver table utensils from Read-Barton. Not a piece is missing, not even the oyster forks. One small item had been

overlooked, however, as this column went to press: There weren't, as yet, any tables or chairs!. . .Detroit is asking Uncle Sam for $378,000 "for educational publicity" to prevent a nurse-shortage in that city. . .Flu took its toll in San Francisco. Public-health nurses planned a party for shut-ins; but when the time came, only the director and one nurse were able to show up at their own party. . .Blanche Edwards, superintendent of nurses at New York's huge Bellevue Hospital, last month gave local newspapers her definition of the perfect nurse. She is, said Miss Edwards, intelligent, fond of people, well-grounded in sciences, healthy, personable—and willing to work like a horse!

—HENRIETTA STREET, R.N.

Soy—economical food

[*Continued from page* 17]

Another soup is made like lentil soup. Add one cup soaked whole beans to one quart meat or vegetable stock. Add one stalk celery, one carrot, one onion, and a hambone. Simmer till beans are tender. Mash through a sieve. Heat strained soup, add a piece of butter, and serve with cut-up frankfurters or with croutons.

Use soybeans, either baked or in the form of a loaf, croquettes, or balls, as a main dish to take the place of meat. They may be served with soy sauce, which has the flavor of a good beef extract and is, furthermore, a valuable aid to digestion. Here are some suggestions:

BAKED SOYBEANS

1 cup boiled whole beans
2 ounces fat salt pork
¼ teaspoon mustard
1 teaspoon cornstarch
⅛ cup molasses
¼ teaspoon salt
½ cup boiling water

Cover bottom of bean pot with ¼ inch slices of salt pork. Fill pot with beans, burying remaining salt pork in the beans. Mix salt, cornstarch, mustard, molasses

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and hot water. Pour in boiling water and mix thoroughly. Cook five hours in a slow oven (300°). Longer cooking seems undesirable for the beans tend to shrivel and harden.

SOYBEAN BALLS

1 cup boiled soybeans
¼ cup cornflake crumbs
½ onion
1 egg
1 tablespoon butter
salt

Chop soybeans. Sauté onion in butter and mix with beans and egg. Shape into balls and roll in breadcrumbs. Fry or bake.

Here's an interesting dish from the Philippines, where Maria Y. Orosa, of the Bureau of Science at Manila, has concocted many intriguing ways of using soybeans:

SOYBEANS WITH BANANAS

½ cup boiled whole soybeans
¼ cup banana, sautéed in butter and sliced
1 egg
¼ cup chopped ham
1 tablespoon chopped onion
1 teaspoon salt

Mix all together and fill custard cups with the mixture. (Fills three medium cups.) Set cups in a pan of boiling water, cover the pan, and cook twenty minutes. Don't have so much water in the pan that it bounces into the cups. Brown in the oven before serving.

Soybean flour is not only a boon for diabetics, but for people who are allergic to wheat or other flours. If possible, soy flour should be combined with wheat flour, since soy flour has little gluten and needs wheat flour as a binder. Bread made with 25 per cent soy flour and 75 per cent wheat flour has forty per cent more protein than white bread, and is a fine, delectable loaf. It is crusty, with a rich creamy color and an enticing flavor. Any proportion up to 30 per cent soy flour is recommended. The same amounts can be used in making cookies. To cooky batter, add raisins, sesame seeds, chopped dates,

nuts, or candied orange peel. If necessary, however, soy flour can be combined with other flours, such as rye or rice. Here are some biscuits made entirely of soy flour:

SOYA BISCUITS

1 cup soybean flour
1½ teaspoons baking powder
¼ cup water
¼ teaspoon salt
1 cup whipping cream

Sift the flour, baking powder and salt together. Combine with cream and water. Place on a floured board and put to a thickness of ½ inch. Bake in a hot oven 15 minutes.

It isn't often an important, brand-new food comes along. This bean that is, perversely, unlike any other bean offers unlimited variations. Public-health nurses who must cope with low-income groups and nurses whose patients are diabetic, allergic, or need high protein or low starch diets should find it a particularly welcome addition to the field of nutrition.

'Where there's a will-'

[*Continued from page* 31]

proceeds turned over to the Alumnae Fund."

Just as I signed my name the buzzer rang. It was Joe. I stuffed my home-made will in my pocket and went downstairs.

"Here's the masterpiece," I said, waving it at Joe, who had the glassy-eyed, pseudo-nonchalant air that most males get when they are on exhibition in a nurses' residence.

He glanced through it. "A few changes—here and here," he muttered. "Uh—anybody make any mental or physical threats or exert undue influence to force you to do this?"

"Considerable coercion from a budding legal light," I answered.

"That doesn't count," said he. "But now comes the tough part. Can you

prove that you're of sound mind?"

I tossed a book at him, lightly, and he ducked. "All right, then, get three witnesses to prove it and to witness this excellent document." I hailed three girls who had just come off duty.

"What's the penalty for perjury on this sound-mind business?" one of them asked Joe.

"Gangsters after you, Roxy?" inquired another sweetly.

After we had all exchanged amicable insults, the girls departed.

"Whew!" I said. "That was a job! But now I can fall down the stairs with a loaded tray and break my neck, or walk in front of a speeding ambulance, and know that my worldly goods and chattels are in proper hands. Although," I added thoughtfully, "it would be fun to be in the middle of a good fight—even after I acquired wings."

"Wings? Humph!" Joe said. "When you get delusions like that, you need black coffee. Let's go!"

Pneumonia treatment

[*Continued from page* 21]

benzene-sulfonamide). Some success attended its use, but it was not considered the final answer. It proved successful in many pneumonia cases but toxic reactions were noted and also a tendency toward acidosis. This was counteracted in part by administering sodium bicarbonate with the drug.

In 1938, sulfapyridine (a sulfanilamide derivative which differs slightly in chemical structure) was introduced into England as M. & H. 693. Since then numerous reports on its use for pneumococcic pneumonia have been favorable. Research from all parts of the world shows that sulfapyridine effects a marked reduction in pneumonia mortality rate. As well as being a specific agent, this drug is readily available, comparatively inexpensive, and easy to administer. The disadvantages of this form of chemotherapy must be noted, however, lest the rather startling results obtained imply that it is free of all danger. Constant attention and the importance of daily blood counts cannot be over-stressed. Toxicity may develop and symptoms of gastro-intestinal upset attended by nausea and vomiting may appear. These reactions seem to be unrelated to the dosage or blood level. Skin rashes, numbness, and manifestations involving the hemopoietic system and urinary tract may also be present. It is most important that any such effects be recognized and reported at once. This is one of the nurse's jobs. She must also see that the drug is given precisely at the hours prescribed by the physician. This is very important because constant blood level of sulfapyridine is desirable.

Bacteriostatic agents, such as sulfapyridine, tend to slow multiplication of the causative organisms, thus allowing antibody production rate to continue. Through this dual action the course of

the disease may be shortened. Dosage must depend upon the individual and the result of observations. It is usually recommended that the initial dose be sufficient to bring the blood concentration to between 3 and 6 mg. per cent of the free drug as soon as possible. Thereafter dosage is sufficient to maintain the concentration. The average adult usually requires 2 gms. followed by 2 gms. in four hours, then 1 gm. every four hours until the temperature, pulse, and respiration have been normal for about forty-eight hours. The dose is then reduced but continued for three to five days.

Nausea and vomiting may be controlled at times by giving the drug in powdered form in fruit juice or milk, by use of gelatin, or by giving smaller doses more frequently. It is important to note that sulfapyridine has been effective against both pneumococci and streptococci and has also been valuable in meningitis. It may be given orally and the cost is materially lower than serum.

Frequently a patient's absorption of sulfapyridine from the intestinal tract is poor, as evidenced by a low blood level of the drug. In these cases a salt of sulfapyridine may be given directly into the blood stream by the doctor. The procedure is to dissolve the salt in hot water just before administering, injecting it very slowly into the vein.

A recent member of the "sulfa" family is sulfathiazole, said to be less toxic than the forerunners of the group. It may also be given in smaller doses. Sulfathiazole will probably replace sulfapyridine before long. All indications point to its superiority and research is now being conducted in army camps. Because of the chemical action of this drug, the body retains for bacteriostasis a higher concentration of sulfathiazole than of other agents. It has proved clinically effective against all types of pneumonia due to pneumococci. Nausea is less severe and fever tends to show a gradual reduction over a period of about forty-eight hours. Massive fluid intake and daily urine examination is recommended, during administration, to prevent hematuria. Although this latter complication may arise, authorities are well agreed that it should not discourage the profession from using sulfathiazole. Good results as a whole exceed the patient's discomfort. Red blood-cell and leukocyte counts are imperative. Owing to the rapid absorption and excretion of the drug it may be necessary to administer it with longer intervals to prevent relapse of the infection.

Oxygen.—The importance of this form of treatment is well known in certain types of pneumonia. Much has been said of the tent and nasal catheter methods. Properly administered, oxygen inhalation has its place with other forms of therapy. It is the responsibility of every nurse to be sure that a nasal catheter is in a correct position when

oxygen is given by this means. The catheter should be directly behind the uvula. Its position can be checked very easily with a flashlight and tongue depressor. Modern administration technique is a vast improvement over early methods. Greater control of temperature, of the rate of flow, and of humidity has increased ease of use—and the comfort of the patient. However, with the advent of serotherapy and chemotherapy, especially in early stages of the disease, routine use of oxygen is not as general as in the past.

Summary.—Great progress in the treatment of pneumonia has truly been made within the past few years. Careful typing and the use of serum and the new drugs, together with oxygen when indicated, have lowered mortality rates considerably. However, rest, baths, and the constant attention of the nurse should never be forgotten in the enthusiasm that has very naturally followed the often spectacular results of these newer methods.

Speech! Speech!

[*Continued from page* 24]

and apt to be the most tiresome. Here you should always remember that there are many who come before and after you on the agenda. Give your facts, and sugarcoat them when possible. Illustrate, and be dramatic. Be as brief as possible. A conversational voice helps, as does a touch of humor, short words, and a climax.

TEACHING. Obey rules for the report, only more so.

MOTION BEFORE THE HOUSE. Here you may do some preparation, but will speak extemporaneously, having cannily sized up your audience beforehand. You want to convince people to vote for or against a measure. Use a debate technique, argue, and be dramatic about it. Don't be afraid to get worked up over the problem. Make one or two points, marshal your arguments, sum them up and sit down. Don't show ire at your opponents; (a slightly sarcastic attitude will help, though).

OCCASIONAL SPEECH. These are sometimes hard to make as there may not be as much to say as in a report. You may be talking before a woman's club, a Sunday School group, or a high school club. Secret of this type of speech is to take a stand on some subject. If you choose "What is Nursing?" you will ramble; it's difficult to leave one clear cut idea with your audience when your chosen topic is so broad. Rather try a subject like "Not everyone should be a nurse." General rules otherwise apply.

TOASTMISTRESS. This is one of the few occasions when you will prepare brief items on all your guest speakers and probably learn them in advance. Each introduction has to be short, funny, and well-timed. Anecdotes are your stock in trade. Get them from a

Clinic dietitians stress the importance of rye and all-rye foods in diets planned for wheat-sensitive patients... frequently include a popular all-rye food in low-calorie diets. But what about whole-rye foods in normal diets? Just what nutrients does whole rye supply? How does rye compare in food value with other cereals?

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R.N.—A JOURNAL FOR NURSES
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SHOE WHITE: ENERGINE Shoe White is unique in two important respects. First, it has a pigment which is the whitest of any used in products of this type. Second, it is not a mixture, but an actual emulsion. It never separates into a thin, watery layer at the top and a chalky deposit at the bottom. ENERGINE Shoe White goes on smoothly and evenly—won't streak or rub off—gives your shoes a clear, smooth, brilliant, *whiter* white. A regular retail size bottle will be sent free on request. Write: The Cummer Products Co., Dept. RN 3-41, 5446 Dunham Road, Bedford, Ohio.

"STORY OF CONSTIPATION": Dr. W. E. Aughinbaugh, well known physician and author, has written an entertaining and informative treatise on the common causes of functional constipation and modern corrective methods. Nurses may obtain copies by writing the Union Pharmaceutical Co., Inc., Dept. RN 3-41, Bloomfield, N.J.

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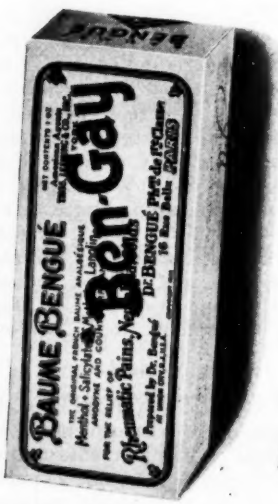

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ADMINISTRATOR: East. Opening in small eastern hospital, health and summer resort; woman 35-45 with administrative experience preferred. Salary, $1,700; maintenance. (Placement bureau charges $2 registration fee.) Box C406.

ANESTHETIST: North. Clinic and hospital appointment. Three anesthetists on staff. Salary around $150. (Placement bureau charges $2 registration fee.) Box MB3-1.

ANESTHETIST: Pennsylvania. Large Pennsylvania hospital offers desirable working schedule. Salary, $100; maintenance. (Placement bureau charges $2 registration fee.) Box C409.

DIRECTOR OF NURSES: New York. Excellent opportunity requiring B.S. degree. Will have assistant and two instructors. Hospital, 150 beds, fairly close to New York City. Salary, $150; full maintenance, including apartment. (Placement bureau charges $2 registration fee.) Box C413.

DIRECTOR OF NURSES: South. Fairly large hospital. Thoroughly experienced executive, preferably Southerner, required. Salary, $200; maintenance, including private suite in new nurses' home. (Placement bureau charges $2 registration fee.) Box MB3-2.

EDUCATIONAL DIRECTOR: East. Teaching background more important than degree. Duties include teaching science; complete charge educational program. Salary, $150; full maintenance. Unusually desirable location, eastern seaboard. (Placement bureau charges $2 registration fee.) Box C414.

GENERAL DUTY: California. Opening in small hospital. Ability to relieve in anesthesia advantageous. Central location. Salary, $95; meals, laundry. (Placement bureau charges $2 registration fee.) Box MB3-3.

***GENERAL DUTY:** East. Immediate opening for several general duty floor nurses. Salary, $70 day duty; $75 night duty. Apply Eastern Dispensary and Casualty Hospital, 8th and Massachusetts Ave., N. E., Washington, D. C.

GENERAL DUTY: Midwest. Openings for several; county institution of 200 beds, combining infirmary for aged with general hospital. No surgical cases accepted. Salary, $90; maintenance. (Placement bureau charges $2 registration fee.) Box MB3-4.

***GENERAL DUTY:** New York. Several openings for New York State registered nurses. Salary, $60, plus maintenance. Box BCH3-1.

***GENERAL DUTY:** New York. Opening for New York State registered nurse for day duty in small hospital. Live in or out. Salary open. Permanent position with advancement. Box BC3-1.

GENERAL DUTY: New York City. Five vacancies on obstetrical floor; four on medical and surgical floors. Six-day week; salary, $82.50, with maintenance, first year; $88, maintenance, second year. Month's vacation following twelve months of service. General hospital meeting standards American College of Surgeons. (Placement bureau charges $2 registration fee.) Box MB3-5.

HEAD NURSE, PSYCHIATRIC: East. For psychiatric division of teaching hospital; small, purely diagnostic service. Must be able to teach psychiatric nursing in correlation with lectures given by the resident in psychiatry. (Placement bureau charges $2 registration fee.) Box MB3-6.

HEAD NURSE, UROLOGICAL: South. Opening in 150-bed hospital in colorful southern city. Pleasant working schedule. Salary open. (Placement bureau charges $2 registration fee.) Box C438.

INTRUCTOR: Latin America. Experienced instructor with degree for teaching staff of fairly large hospital. Knowledge of or ability to learn Spanish necessary. Salary sufficient to attract best qualified individual. (Placement bureau charges $2 registration fee.) Box MB3-7. [*Turn the page*]

*Not listed by placement bureau.

INSTRUCTOR, NURSING ARTS: East. Large hospital seeks eastern graduate with B.S. degree. Salary $150; full maintenance. (Placement bureau charges $2 registration fee.) Box C422.

INSTRUCTOR, NURSING ARTS: Michigan. Duties will include teaching of anatomy and physiology at accredited Junior College. Salary, $135; maintenance. (Placement bureau charges $2 registration fee.) Box MB3-8.

LABORATORY AND X-RAY TECHNICIAN: Washington. Must be experienced in blood matching and general routine laboratory work. Busy well-equipped X-ray department. Small hospital. Salary, $125. (Placement bureau charges $2 registration fee.) Box MB3-9.

***OFFICE NURSE:** New Jersey. Opening for registered nurse, preferably married, for part-time work, some evenings and Saturday afternoons, in

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RECORD LIBRARIAN: Virginia. Fairly large hospital. Duties will include some medical dictation in addition to handling records. Minimum salary, $85; maintenance. Early increase for thoroughly experienced person. (Placement bureau charges $2 registration fee.) Box MB3-10.

STUDENT-HEALTH NURSE: West. Previous student health experience unnecessary. Graduate nurse above college age with fairly recent training in general nursing preferred. Duties will include office care of ambulatory patients under direction of two physicians. Large university. Salary about $110. (Placement bureau charges $2 registration fee.) Box MB3-11.

SUPERINTENDENT, INDUSTRIAL: Midwest. Small industrial hospital serving interests of nearly 4,000 employees representing three companies. Graduate nurse in her thirties who has served as assistant superintendent desired. Salary, $150; private suite. (Placement bureau charges $2 registration fee.) Box MB3-12.

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SUPERVISOR, FRACTURES: Midwest: Men's fracture ward accommodates 85-90 patients; large municipal hospital. Salary, $92.50; maintenance. (Placement bureau charges $2 registration fee.) Box MB3-14.

***SUPERVISOR, GENERAL DUTY:** Midwest. Opening in small hospital in college town; 13-bed floor. Prefer candidate interested in surgery. Box C1H3-1.

SUPERVISOR, MEDICAL: Southwest. Duties involve supervision of four units having bed capacity of 60 patients. Will be responsible for sponsoring doctors' classes. University hospital. (Placement bureau charges $2 registration fee.) Box MB3-13.

SUPERVISOR: OBSTETRICAL. California. Large hospital requires nurse with degree, post-graduate in obstetrics, and teaching ability. Salary $115; full maintenance. (Placement bureau charges $2 registration fee.) Box C423.

SUPERVISOR, OPERATING ROOM: New England. Experience in organization and management of large operating room suite required. One of leading hospitals in New England States. Very minimum salary, $125; maintenance. (Placement bureau charges $2 registration fee.) Box MB3-15.

SUPERVISOR, OUTPATIENT DEPT.: New York. Small department in excellent hospital. Staff includes medical director, medical social worker, and general-duty nurse. Interesting appointment. Prefer public-health nurse with sound educational background. During 1940, department had 6,000 visits, 1,500 admissions. Salary, $100; partial

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maintenance; attractive hours. (Placement bureau charges $2 registration fee.) Box MB3-16.

SUPERVISOR, PEDIATRIC: New England. To take charge of 32-bed hospital. Several graduate nurses on staff nurse level will assist. Graduate of children's hospital preferred. Salary, $125; maintenance. (Placement bureau charges $2 registration fee.) Box MB3-17.

SUPERVISOR, SURGICAL: West. West Coast hospital offers opening for candidate with teaching ability (essential); interesting location. Salary, $110; full maintenance. (Placement bureau charges $2 registration fee.) Box C436.

SUPERVISOR, TUBERCULOSIS: Midwest. Tuberculosis division of municipal hospital group, 675-bed service. Executive experience required. Salary $1,980; maintenance. (Placement bureau charges $2 registration fee.) Box MB3-18.

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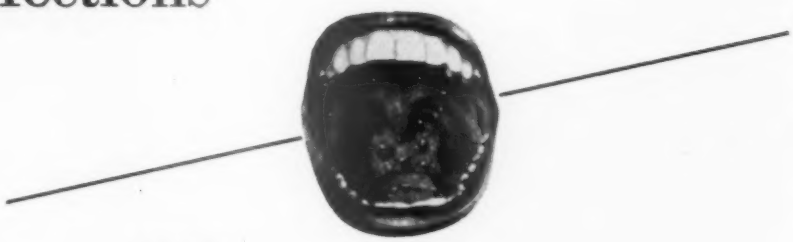

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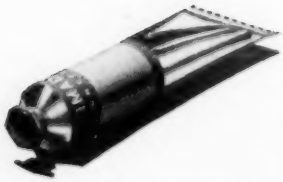

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